Healthy Way LA Eligibility Status Request

Date of Request:

Contact Information

Provider no. & name: _____

Phone no.: _____ Fax: _____

Requested by (*name of contact person*): _____

e-mail address: _____

Requested Information

Please identify name of client(s) whom you would like RMD to verify enrollment in Healthy Way LA. Provide as much information as possible.

Client #1

Full Name	_____
DMH IS ID#	_____
Date of Birth	_____
SSN	_____

Client #2

Full Name	_____
DMH IS ID#	_____
Date of Birth	_____
SSN	_____

Client #3

Full Name	_____
DMH IS ID#	_____
Date of Birth	_____
SSN	_____

Client #4

Full Name	_____
DMH IS ID#	_____
Date of Birth	_____
SSN	_____

Client #5

Full Name	_____
DMH IS ID#	_____
Date of Birth	_____
SSN	_____

Client #6

Full Name	_____
DMH IS ID#	_____
Date of Birth	_____
SSN	_____

RMD Tracking Information (RMD Use Only)

Request no.:	
Opened by:	Date opened:
Request assigned to:	Date assigned:
Closed by:	Date closed:

Fax your request to Revenue Management Division at (213) 252-8889